THE INTERSECTION OF RACE AND SEXUALITY IN A NATIONAL SAMPLE: EXAMINING DISCRIMINATION AND MENTAL HEALTH

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ABSTRACT

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The current study examined the experiences of race and sexuality related mistreatment in 2,335 racially diverse sexual minorities, the impact of those experiences on depression and anxiety symptoms, and the buffering effects of racial identity and social support. Zero inflated Poisson regression models were utilized for data analysis. Despite sexual minorities of color endorsing more frequent racial- and sexuality-based discrimination compared to their White counterparts, findings indicate they had similar levels of anxiety and depression. Positive racial identity and social support varied by race. Importantly, social support was significantly associated with a decrease in depression and anxiety symptoms for Black sexual minorities with any symptoms. These findings suggest that at low levels of discrimination, sexual minorities of color appear to have resilience against some of the negative psychological consequences of experiencing both race- and sexuality-based discrimination, when compared to White sexual minorities. The resilience against racial discrimination, taught through racial socialization from an early age for many people of color, may generalize to resilience against sexuality-based discrimination. Given the variation of results across racial minorities, this study underscores the importance of an approach to race that preserves each racial groups' unique experiences of discrimination and mental health. Implications of a multidimensional approach to sexuality, challenges in addressing intersectional experiences, and considerations for clinicians working with these vulnerable populations are discussed.

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Introduction

An expanding body of literature demonstrates that persistent mental health disparities exist across and within minority groups. The vast majority of inequity research has explored racial disparities. Research addressing inequities related to sexual orientation is in its nascent stages and there is very little addressing both race and sexual orientation simultaneously. Because sexual minority research rarely addresses race and race research rarely addresses sexuality, health inequities research examining individuals who identify with multiple minority identities is rare (exceptions include Bowleg, 2008, 2012; Bowleg et al., 2003; Buchanan, 2015; Buchanan et al., 2018). Given that discrimination, marginalized identities, and intersecting identities may create heightened risk for a wide variety of negative psychological symptoms, their exploration is imperative (Bostwick et al., 2014; Settles & Buchanan, 2014).

Compared to Whites, racial minorities in the United States report fewer mental disorders overall, however, when present, systemic disparities in access to care, clinical biases and societal inequalities create disproportionally worse consequences (Baker et al., 2010; Budhwani et al., 2015; McGuire & Miranda, 2008). Racial and ethnic minority adolescents in psychological distress are more likely to be directed toward the juvenile justice system than to mental health care services relative to White adolescents (Losen et al., 2014). When presenting with the same symptoms, Black adults are more likely to receive a diagnosis of schizophrenia while White adults are more likely to be diagnosed with a mood disorder, such as depression (Bell et al., 2015). The effects of such a misdiagnosis can be catastrophic considering that Black individuals with mental illness, particularly schizophrenia, are more frequently incarcerated compared to individuals of other races (Hawthorne et al., 2012). According to the 2017 National Healthcare Quality and Disparities report, all racial minorities experience worse access to care compared to

White individuals (Gray et al., 2017). While Black individuals routinely lack access to competent mental health care and consequently have lower outpatient utilization rates, their utilization of inpatient services is higher compared to all other races (Substance Abuse and Mental Health Services Administration, 2015). Given that racial minorities are projected to constitute more than half of the U.S. population by 2044, addressing these health disparities is a matter of public health (Colby & Ortman, 2015).

Sexual minorities are more likely to live with depression, anxiety, and suicidality compared to heterosexuals in the United States (Kates et al., 2018; Rice et al., 2019). Those who endorse engaging in bisexual behavior have the highest rates of mood and anxiety disorders compared to their lesbian, gay, or heterosexual counterparts (Bostwick et al., 2010; Ross et al., 2018) and are more likely to struggle with a severe substance use disorder (Boyd et al., 2019). Adolescents that identify as lesbian, gay, and bisexual attempt suicide at four times the rate of their heterosexual peers (Kann et al., 2016). Despite advances toward equity with marriage equality and the Affordable Care Act, sexual minorities continue to face issues with accessing care due to discrimination and stigma (Skopec & Long, 2015) and are at an increased risk of experiencing violence compared to heterosexuals (Waters et al., 2018). Taken together, the available literature on discrimination, violence, and isolation paint a picture of an increased risk for psychological distress for the estimated nine million people in the United States that identify as lesbian, gay, bisexual, or transgender (Gates, 2011). Given that an estimated 19 million Americans reported engaging in any same-sex sexual behavior across the lifespan, these mental health issues may impact an larger portion of the population than initially estimated (Gates, 2011).

The few studies that have explored mental health outcomes for those that are both racial and sexual minorities provide contradictory results. One study found that Black sexual minority women reported increased experiences of discrimination and poorer psychological well-being than White sexual minority women and Black sexual minority men (Calabrese et al., 2015). A recent study utilizing a nationally representative dataset found that Black sexual minorities reported lower levels of psychiatric disorders than White sexual minorities and Latinx sexual minorities reported a similar incidence of psychiatric disorders compared to their White counterparts (Rodriguez-Seijas et al., 2019). Risk for symptoms of mental illness is positively correlated with experiences of discrimination and with increased frequency and type of discrimination experienced (Bostwick et al., 2014). Rates of psychological distress notwithstanding, racial minority gay men are more likely to struggle with internalized homophobia (Chard et al., 2015) and are less likely to access mental health care due to stigma (Storholm et al., 2013). Racial minority lesbian, gay, bisexual, or transgender individuals are even more likely to be victims of violence than White heterosexual individuals. In 2017, 59.6% of the victims of reported hate crimes were targeted for their race or ethnicity and 15.8% of victims were targeted because of their sexual orientation (U.S. Department of Justice, 2017). Given the lack of concrete literature examining the impact of both racial and sexual minority statuses on mental health outcomes, there is a critical need to perform this analysis.

Intersectionality, Multiple Jeopardy, and Mental Health

Legal scholar and critical race theorist, Kimberlé Crenshaw, coined the term *intersectionality* to highlight that individuals' identities cannot be analyzed separately because they exist interdependently (Crenshaw, 1990). Intersectionality theory posits that the separate analysis of race, class, sexuality or gender does not fully characterize an individual's particular

and unique experience (Cole, 2009) and demands that social science research examine the experiences of real people and their lives as they live them (Settles & Buchanan, 2014). With regard to health inequities, the increased research examining minority mental health has been limited by the relative lack of intersectional theory and analysis, which affects findings and implications of this work and limits its ability to decrease disparities.

Connected to intersectionality, multiple jeopardy describes the multiple biases faced by individuals that hold multiple marginalized identities (Beal, 1970; King, 1988). Multiple jeopardy requires intersectionality as the framework for understanding the layers of discrimination faced by individuals that is not captured when race, gender, or sexuality are examined in isolation (Bowleg et al., 2003; Settles & Buchanan, 2014). Using an intersectional framework, it would stand to reason that a bisexual Latinx woman is subject to victimization based on her race, sexuality, and gender, as well as the unique manifestations of sexualized racial bias for example.

According to minority stress theory (Brooks, 1981; Meyer, 2003), stigma, prejudice, and discrimination generate stressful social environments that in turn lead to increased psychological distress among individuals of marginalized groups. A multicultural model of the stress process explains the cyclical nature of stress while living in the U.S. as a member of a marginalized group (Slavin & Rainer, 1991). Stressful events burden an individual's coping mechanisms and in turn may increase vulnerability to stress, contributing to worse future outcomes (Slavin & Rainer, 1991). Many studies support the connection between experiences of discrimination and negative mental health outcomes, particularly symptoms related to anxiety or depression in sexual minority individuals (Bostwick et al., 2014; Calabrese et al., 2015; Lee et al., 2016) and racial/ethnic minorities (Budhwani et al., 2015; Krieger et al., 2005; Schmitt et al., 2014; Sellers

& Shelton, 2003). Sexual minority women who experience discrimination based on their sexual orientation report increased physical health problems (Frost et al., 2015) and increased risk of mood and anxiety disorders (Lee et al., 2016).

Alternatively, individuals marginalized due to bias associated with both race and sexuality may have developed greater resilience compared to White sexual minorities, thus explaining some of the inconsistent findings (Meyer, 2010). A smaller body of literature in support of resiliency models suggest that multiple marginalization may promote a unique psychological capacity to achieve positive development in the face of adversity as a combination of the individual and their environmental context (Ungar & Liebenberg, 2011). Growing up within a racially marginalized community provides shared group experiences that help contextualize discriminatory experiences (Hughes et al., 2006; Neblett et al., 2012; Postmes & Branscombe, 2002) and parents of color engage in racial socialization techniques to help children develop resilience against racism (Brown, 2008; Fischer & Shaw, 1999; Ifill et al., 2018; Johnson, 2004; LaSala & Frierson, 2012). Facing racial discrimination from birth leads to the development of skills and coping strategies that can translate to combating heterosexism (Fitzgerald et al., 2019; Greene, 1994; Stone et al., 2020). A combination of racial socialization and personal traits has been found to foster resilience in Black lesbians in particular (Bowleg et al., 2003, 2004).

Most White sexual minorities are not socialized to prepare them for identity-based discrimination. Racial minorities with parents and communities with a shared racial experience are taught ways to protect themselves against the inevitable stigma they will face for their race (Brown, 2008). Most White sexual minorities grow up in predominately heterosexual environments and are not afforded the same socialization to educate them on the stigma and

barriers they will face due to their sexuality (Mendez, 2020; Simon & Farr, 2020). Sexual minorities that are White are not typically raised in communities with shared sexuality experiences and thus do not develop the psychological adjustment skills used to face discrimination that result from racial socialization for sexual minorities of color (Neblett et al., 2008). White individuals that report racial discrimination tend to be disproportionately male, with higher levels of income and education (Pincus, 2000) and are more likely to be evangelical Protestants and politically conservative (Mayrl & Saperstein, 2013). These findings intimate that White individuals with more privileged identities (socioeconomic, religious, education) are more likely to report anti-White bias. It may be that in the face of negative events, more privileged identities are risk factors for not having the coping skills to endure discriminatory events (Allen, 2020; Hagerman, 2014; Marshall, 2002). Taken together, individuals multiply marginalized by race and sexuality may actually be protected by greater resilience compared to White sexual minorities. While work focused on the mental health outcomes for sexual minority individuals is growing, there is a paucity of research on the unique experiences of risk and resilience for racial sexual minorities and little is known about the ways their identities interact to affect mental health outcomes (Cyrus, 2017).

Racial Identity and Social Support as Protective Factors

A critical aspect of examining mental health outcomes in marginalized communities is exploring individual strengths and protective factors that may buffer against the additive nature of multiple minority stress. For example, a stronger sense of racial identity may be a protective factor against perceived discrimination (Schmitt et al., 2014; Sellers & Shelton, 2003). Rosenfield (2012) found that stronger racial identity in Black women and men was related to lower rates of depression when compared to their White counterparts with similar education

levels. In conjunction with experiencing discrimination, negative self-views or internalized racism has been related to lower psychological well-being (Velez et al., 2019). For sexual minority individuals, a positive sense of their sexual identity has been linked to lower levels of depression (Kertzner et al., 2009) and greater well-being (Mohr & Kendra, 2011). Similarly, internalized heterosexism has been shown to increase psychological distress (Velez et al., 2015). There are no data examining whether a strong racial identity could be protective against negative events related to discrimination based on another marginalized identity, however it is important to note the difficulty in separating forms of oppression based on specific identities in individuals who hold multiple identities.

Social support may be a buffer against stressful life events and a protective factor for both physical and mental health (Cohen et al., 1985, 1997). In a review of 148 studies, individuals with strong social relationships had a 50% increased probability of survival when compared to counterparts with fewer social connections (Holt-Lunstad et al., 2010) and positive relationships within a wide social network benefited individuals exposed to high levels of stress (Sehmi et al., 2019). In a college sample, social support was positively correlated with resilience among Black students (Brown, 2008). The presence of social support, and specifically higher quality interpersonal relationships may act as a protective factor against depressive symptoms for racial minorities (Plant & Sachs-Ericsson, 2004). For sexual minorities, having access to other sexual minorities, individually or as a community, reduces psychological distress (Puckett et al., 2015). In a study examining gay and bisexual men, community connectedness was associated with lower rates of perceived sexual discrimination and a greater likelihood of having a primary care provider (Anderson-Carpenter et al., 2018). For individuals who are both sexual and racial minorities, positive support from their racial group has been associated with mitigating

experiences of discrimination (Balsam et al., 2015; Greene, 2000) and positive social support based on racial identity was found to outweigh sexual identity support for Latinx young adults (Snapp et al., 2015). Given that positive racial identity may protect racial minorities when faced with discrimination and social support buffers the effects of discrimination for sexual minorities, both racial identity and social support are important protective factors to include in studies of sexual minorities of color.

Dimensions of Sexuality

Sexual orientation is a dimensional construct reflecting an individual's attraction, behaviors, and sexual identity (Rosario & Schrimshaw, 2014). Despite these three domains, most studies only include individuals that label themselves as lesbian, gay, or bisexual and exclude individuals who may not endorse these labels, but have same gender experiences and attractions (L.M. Diamond, 2014; Patterson et al., 2017). Approximately nine million Americans self-identify as lesbian, gay, bisexual or transgender, but over 19 million Americans have engaged in same-sex sexual behavior (Gates, 2011). While individuals may develop their sexual identity by recognizing themselves with a label of straight, gay, lesbian, or bisexual, they may also face stigmatization based on who they are attracted to and who they engage with sexually (Mohr & Kendra, 2011). The variation in how sexual orientation is studied may be problematic given that identity, behavior, and attraction may be distinct facets of an individual's overall sense of sexuality (Badgett, 2009; Lisa M. Diamond, 2000; Paschen-Wolff et al., 2019). In fact, one study that utilized a multidimension measure of sexuality found variations in mental health outcomes based on self-identification, sexual behavior, and attraction (Bostwick et al., 2010). Only including individuals who self-identify as lesbian, gay, or bisexual in mental health research risks further stigmatizing these labels and narrowing the generalizability of sexuality research.

Expanding the inclusion criteria to fit a multidimensional model of sexuality broadens our clinical knowledge to include more people that may have similar risk and resilience factors based on their attraction or behavior.

The Current Study

The proposed project is a secondary data analysis of participant responses to the National Institute on Alcohol Abuse and Alcoholism's National Epidemiologic Survey on Alcohol and Related Conditions-III (NESARC-III; Grant et al., 2015; National Institute on Alcohol Abuse and Alcoholism (NIAAA), 2015). This study will expand the current literature by using a large and racially diverse sample of sexual minority adults to examine experiences of race- and sexuality-related mistreatment, their impact on both depression and anxiety, and the potential buffering effects of racial identity and social support on depression and anxiety following race- and sexuality-based discrimination.

Utilizing an intersectional framework, this study aims to fill a gap in the literature by focusing on the comprehensive lived experiences of individuals with multiple marginalized identities. Rather than separating race from sexuality and gender, this analysis intends to integrate multiple jeopardy and minority stress theory into the examination of how discrimination experiences interact with multiple identities. By examining multiple types of negative identity-based events, similarities and differences between sexuality-based or race-based discrimination will be explored. These discriminatory experiences may affect individuals differently based on their unique race and sexuality combinations.

The proposed study will also expand the extant literature by utilizing a more inclusive and representative measurement of sexuality. Specifically, sexual minorities will broadly be defined as individuals who selected a sexual minority identity (lesbian, gay or bisexual) as well

as anyone who reported same-gender attractions or sexual behaviors. By including individuals based on these dimensions of sexual behavior and attraction, this study aims to expand sexual minority research beyond the singular focus on individuals that self-identify as lesbian, gay or bisexual.

In an effort to move this body of literature toward an action-oriented social justice purpose, the proposed study will include the exploration of protective factors and apply a strengths-based perspective. While understanding the potential risks for poor mental health outcomes is important to guide the focus of the field, implications for future work that will decrease health disparities should be informed by the strengths that already exist within the communities of interest. While sexual minorities do report higher rates of psychological distress, there is variation within this population that warrants study. There lacks a clear consensus around the risk or resilience associated with multiply marginalized identities. However, adequate evidence supports the psychological harm caused by discrimination. By investigating protective factors may improve mental health, we begin to approach solutions for these disparities. Toward this goal, this study will investigate how social support and racial identity relate to discrimination experiences and outcomes in sexual minorities of color.

The proposed study will benefit the growing literature by utilizing a large and robust nationally representative sample. Minority populations are often difficult to study quantitatively due to their smaller size in the general public. As a result, research involving racial and sexual minorities of color is growing, but most studies are small in size and utilize convenience sampling. Findings from a nationally representative sample, such as that used here, are more likely to generalize to the broader population and should prove to be useful in understanding

their potential implications. Using theoretical and empirical perspectives on intersectionality, multiple jeopardy, resilience, and minority stress, this study poses the following hypotheses:

1. Discrimination
    a. Sexual minorities of color will report higher rates of racial discrimination compared to Whites sexual minorities.
    b. Sexual minorities of color will report higher rates of sexual discrimination compared to Whites sexual minorities.
2. Mental health
    a. Sexual minorities of color will report higher rates of anxiety and depression symptoms compared to White sexual minorities.
3. Discrimination and mental health
    a. Racial discrimination will be associated with increased symptoms of anxiety and depression in sexual minorities of color compared to White sexual minorities.
    b. Sexuality discrimination will be associated with increased symptoms of anxiety and depression in racial minorities of color compared to White sexual minorities
    c. The additive experiences of both sexuality- and race-based discrimination will be associated with increased symptoms of anxiety and depression in sexual minorities of color compared to Whites sexual minorities.
4. Protective factors
    a. Racial identity will attenuate the relationship between discrimination and symptoms of anxiety/depression for sexual minorities of color such that those with stronger positive racial identity will have fewer symptoms of anxiety/depression compared to Whites sexual minorities.

b. Social support will attenuate the relationship between discrimination and symptoms of anxiety/depression such that sexual minorities of color with more social support will have fewer of anxiety/depression symptoms compared to Whites sexual minorities.

Methods

Procedures

The National Institute on Alcohol Abuse and Alcoholism's National Epidemiologic Survey on Alcohol and Related Conditions-III (NESARC-III) is a longitudinal study with three waves of data collection. The first wave of data in 2001-2002, the second wave in 2004-2005 and the third wave in 2012 -2013. Fieldwork was conducted by Westat, a professional research service provider. Data was collected via face-to-face interviews with trained staff interviewers that lived in the same geographic regions where the interviews took place. Westat utilized the U.S. Postal Service Computerized Delivery Sequence and multistage probability sampling to randomly sample households. Data from the U.S. Census summary file was used to further define block segments and the demographics of the area and within the individual household. Field interviewers were responsible for screening the household and identifying at least one eligible participant. Additional details regarding NESARC-III procedures are presented in past studies (see Grant et al., 2015; Hasin et al., 2015; Ruan et al., 2008).

All potential participants received written information regarding the purpose of the survey, potential use of the data, voluntary consent and participation and Federal laws governing confidentiality. The Westat Institutional Review Board and the Combined Neurosciences Institutional Review board of the National Institutes of Health provided full ethical review and approval of the research protocol and informed consent procedures. Participants were compensated $90 in two installments during the process of screening and completion of the interview.

The full sample included 36,309 civilian participants, aged 18 years and older, residing in noninstitutionalized housing in the Unites States. The total sample (N= 36,309) self-identified as

43.7% male (*n* = 15,862) and 56.3% female (*n* = 20,447), with additional gender representations not identified. The racial demographics are 52.9% White (*n* = 19,194), 21.4% Black (*n* = 7,766), 5.0% Asian/Pacific Islander (*n* = 1,801), 1.4% Indigenous/Alaska Native (*n* = 511),and 19.4% Latinx/Hispanic (*n* = 7,037).

Sexuality was measured via identity, attraction, and behavior. Participants identified as 96.25% heterosexual (n = 34, 644), 3.75% gay, lesbian, or bisexual (*n* = 1,351), and 0.5% as not sure (*n* = 199). Participants that endorsed a heterosexual attraction made up 94.83% of the sample (*n* = 34,114), 5.17% endorsed sexual minority attraction (*n* = 1,860). For lifetime sexual behavior, 93.59% of participants reported heterosexual sexual behavior (*n* = 33,639), and 6.41% reported sexual minority sexual behavior in their lifetime (*n* = 2,305). For sexual behavior within the last year, 95.34% of participants reported only heterosexual behavior (*n* = 24,525), 4.66% reported sexual minority behavior (*n* = 1,198), and 27% of participants reported that they had not engaged in any sexual behaviors with a partner (*n* = 9,812).

The current analysis focused on a subset of participants based on either sexual minority identity (lesbian, gay, or bisexual), sexual minority behavior in the past 12 months, or sexual minority attraction. Participants who endorsed a sexual minority aspect of any of the three facets of sexuality were included. This subset of sexual minority respondents (N = 2335) was the basis of all analyses. The sexual minority sample identified as 40.9% male (*n* = 955) and 59.1% female (*n* = 1380). The racial demographics are 52.4% White (*n* = 1224), 23.2% Black (*n* = 541), 4.6% Asian or Pacific Islander (*n* = 107), 1.3% Indigenous/Alaska Native (*n* = 31), and 18.5% Latinx/Hispanic (*n* = 432).

Measures

Unless stated otherwise, measures were coded such that higher scores indicated greater endorsement of the construct. Participants self-reported their demographic characteristics. Participant sex was assessed asking, "What is your sex?" with the option choices of male or female. For race. participants selected one or more categories on a flashcard (White, Black or African American, Asian, Native Hawaiian or Other Pacific Islander and Indigenous or Alaska Native) and were asked, "Are you of Hispanic or Latino origin?" (yes or no) to assess ethnicity.

Sexuality

Sexuality was measured by three dimensions, identity, attraction, and behavior. Sexual identity was assessed by asking, "Which of the categories on the card best describes you: (1) heterosexual, (2) gay or lesbian, (3) bisexual, or (4) not sure?". Sexual attraction was measured by asking, "People are different in their sexual attraction to other people. Which category on the card best describes your feelings: (1) only attracted to females, (2) mostly attracted to females, (3) equally attracted to females and males, (4) mostly attracted to males, or (5) only attracted to males?". Sexual behavior was considered by asking all respondents, "In your entire life, have you had sex with only males, only females, or both males and females, or have you never had sex?". If the participant endorsed having sex in their life they were asked, "Have you had sex in the last 12 months?". If they responded affirmatively, they were asked, "During the last 12 months, did you have sex with (1) only males, (2) only females, or (3) both males and females?". Reported kappa values for sexual identity, sexual attraction, and sexual behavior range between .60-.66 (Ruan et al., 2008).

Discrimination

Self-reported experiences of discrimination were assessed with six items adapted from the Experiences of Discrimination (EOD) Scale (Krieger, 1990). The EOD scale was designed to separately assess discrimination experiences based on race, sexuality, or ethnicity. Participants used a 5-point response scale ranging from 0 (*never*) to 4 (*very often*) to report lifetime experiences and experiences within the past 12 months across a variety of situations, such as at school, work, getting medical care, getting service in a restaurant, and in public or street settings as well as with police or the court system. Past studies have suggested good internal reliability of the EOD across racial groups with a Cronbach's alpha of .74 for the original 9-item version (Krieger et al., 2005) as well as for EOD scale for sexual orientation (α = .84) (Ruan et al., 2008).

Mental Health Outcomes

Psychiatric disorders and well-being were assessed using the NIAAA Alcohol Use Disorder and Associated Disabilities Interview Schedule-5 (AUDADIS-5; Grant et al., 2015). The AUDADIS-5 is a structured interview designed to asses for alcohol, drug and mental disorders according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition diagnostic criteria (DSM-5; American Psychiatric Association, 2013). When administered as directed, the interview has been found to have good to excellent reliability for substance use disorder diagnoses and associated criteria scales (.41 - .87), and fair to good reliabilities for mood, anxiety and trauma and stress-related disorders and associated scales (.40 – .51) (Grant et al., 2015). The AUDADIS-5 assessed lifetime occurrence of anxiety and mood disorders as well as whether an episode occurred in the past year.

Anxiety was assessed using a 21-item self-report measure of general anxiety disorder (GAD) symptoms as defined by the diagnostic criteria from the DSM-5. Participants answered either yes or no to questions targeted at specific GAD diagnostic symptoms (e.g., feel keyed up or on edge, have tense, aching muscles, become so restless that you fidgeted, paced, or couldn't sit still). Past studies have found the reliability of the interview schedule for dimensional measures of GAD to be good with an intraclass correlation coefficient (ICC) of .79 (95% CI, .72 to .83)(Grant et al., 2015).

Symptoms of major depressive disorder were assessed using a 28-item self-report interview from the AUDADIS-5 section on low mood. Symptoms of persistent depressive disorder were assessed using a 20-item self-report interview from the AUDADIS-5 secondary section on low mood. Both assessments for depressive symptoms were based on DSM-5 criteria. MDE related symptoms were assessed by asking yes or no questions related to appetite, weight gain or loss, difficulties with sleep, energy and feelings of worthlessness. Symptoms of dysthymia was assessed by asking yes or no questions related to having a low mood that lasted for two years or longer. Past studies have found the reliability of the interview schedule to be good for dimensional measures of MDE (ICC = .59, 95% CI, .50 to .65) and dysthymia (ICC = .65, 95% CI, .58 to .70) (Grant et al., 2015).

Protective Factors

Racial identity and social support will be explored as potential protective factors that buffer mental health outcomes. Racial and ethnic identity was assessed with an eight-item race-ethnic identification scale. This measure was adapted from previous scales that were utilized among racially diverse groups as a way of measuring an individual's concept of self that originates from their knowledge of and perceived membership within a racial social group (Ruan

et al., 2008). Items conceptualized race-ethnic identification, pride, importance of heritage ("Your Hispanic or Latino heritage is important in your life"), the role of race-ethnic background in interactions with others ("You are more comfortable in social situations where other African Americans are present"), and shared values, attitudes, and behaviors ("Your values, attitudes and behaviors are shared by people of Hispanic or Latino origin"). Participants used a 6-point response scale ranging from 1 (*strongly agree*) to 6 (*strongly disagree*). Ruan and colleagues (2008) reported the reliability of the interview schedule for race-ethnic identification to be .79.

Social Support was assessed with the 12-item abbreviated version of the Interpersonal Support Evaluation List (ISEL-12; Cohen et al., 1983, 1985). Participants were asked about their current potential support systems ("there is someone I can turn to for advice about handling problems with my family") as well as their perception of themselves in a social network ("I don't often get invited to do things with others"). Participants used a 4-point response scale ranging from 1 (*definitely false*) to 4 (*definitely true*). Past studies have found the reliability of the ISEL-12 to be good ($\alpha = 0.82$) (Ruan et al., 2008).

Data Analysis

Statistical analyses were performed in R v1.2.5033 (R Core Team, 2019). To examine differences in discrimination and mental health among racial groups, one-way ANOVA with post-hoc Tukey tests were performed. Exploration of the distributions for each outcome variable revealed that 75% of participants reported zero experiences of sexuality-based discrimination, 64% reported zero experiences of racial discrimination, 78% reported zero anxiety symptoms, and 59% reported zero depression symptoms. Frequency of discrimination experienced and number of depression and anxiety symptoms, were treated as count variables. Count variables are defined as having values that are always whole numbers, with the lowest possible value of

zero, and are often skewed such that a majority of the values are relatively low within the distribution (Cameron & Trivedi, 1998).

Due to the zero inflation in responses for discrimination and mental health outcomes, a zero inflated Poisson (ZIP) model was used in the related hypothesis testing (Atkins & Gallop, 2007) with use of the *zeroinfl* package (Zeileis, Kleiber, & Jackman, 2008). A ZIP models the disproportionate number of zeros of the outcome variable by approximating two separate models and distributions (Beaujean & Grant, 2016). Within the ZIP, a logistic regression is first utilized to examine occurrence and predict non-occurrence, such that the difference between a zero and a non-zero is determined. Next, a Poisson regression is utilized to examine the frequency of occurrence for the outcome conditional on the excess zeros (Atkins & Gallop, 2007; Beaujean & Grant, 2016; Rose et al., 2006). Given the different interpretations of each model, the count model predicting the frequency of the outcome can produce a rate ratio (RR) while the logistic portion of the model is interpreted as an odds ratio (OR) of being a zero within the distribution (Atkins et al., 2013). A Vuong (1989) goodness-of-fit test determined that a ZIP model was the best fitting model for this data compared to negative binomial or linear regression models.

Results

Table 1 contains the demographic characteristics of the study sample. Ages of participants ranged from 18 to 90 years (M = 41.89, SD = 17.57). Of those that endorse some aspect of sexual minority status (i.e., identity, behavior, or attraction), 57.9% identified as lesbian, gay, or bisexual (n = 1,351), 79.67% endorsed attraction (n = 1,860), 76.5% reported lifetime sexual behavior (n = 1,787), and 51.3% (n = 1,198) endorsed sexual behavior in the past 12 months. Gender and age were significantly different between racial groups, and thus, were used as control variables throughout the analysis.

Table 1:
Demographic Characteristics of Sexual Minority Population Only

	Total (N = 2335)
Age	
18-24	18.9% (441)
25-44	40.0% (935)
45-64	28.8% (672)
≥ 65	12.3% (287)
Sex	
Male	40.9% (955)
Female	59.1% (1380)
Race/Ethnicity	
American Indian or Alaskan Native	1.3% (31)
Asian or Pacific Islander	4.6% (107)
Black or African American	23.2% (541)
Hispanic/Latinx, any race	18.5% (432)
White	52.4% (1224)
Sexual Minority Facet	
Identity	57.9% (1351)
Behavior, lifetime	76.5% (1787)
Behavior, past 12 months	51.3% (1198)
Attraction	79.67% (1860)

Experiences of Discrimination

Lifetime experiences of racial discrimination among participants who reported any discrimination, were more common among sexual minorities of color, Black, Indigenous, Asian,

and Latinx identities, compared to Whites. The odds of reporting zero lifetime racial discrimination were significant and negatively associated with being a sexual minority of any marginalized race. The odds of reporting zero lifetime sexuality-based discrimination were lower for Black (OR = 0.33, 95% CI = .07, .58, p = .04), and Asian (OR= 0.68, 95% CI = 0.11, 1.20, p = .04) sexual minorities compared to White sexual minorities. Among participants who did report any sexuality-based discrimination, lifetime rates were higher for Black (RR= 1.18, 95% CI = 1.07, 1.29, p = .002) and lower for Indigenous (RR = 0.62, 95% CI = 0.42, 0.92, p = .02) sexual minorities when compared to their White counterparts.

Table 2:

Zero-Inflated Poisson (ZIP) Regressions for Race Predicting Racial Discrimination

	ZIP					
Variable	*Estimate*	*SE*	*OR*	*LCL*	*UCL*	*p-value*
Count portion of model						
Intercept (White)	0.68	0.08	1.97	0.53	0.83	<.0001
Black	0.44	0.05	1.55	0.34	0.54	<.0001
Indigenous	0.54	0.13	1.71	0.28	0.79	<.0001
Asian	0.26	0.09	1.30	0.08	0.44	0.004
Latinx	0.53	0.06	1.70	0.42	0.64	<.0001
Gender	0.07	0.04	1.07	-0.01	0.15	0.09
Age	0.00	0.00	1.00	0.00	0.01	<.001
Logistic portion of model						
Intercept (White)	0.40	0.16	1.49	0.08	0.72	0.014
Black	-1.40	0.12	0.25	-1.63	-1.17	<.0001
Indigenous	-1.22	0.38	0.30	-1.96	-0.48	0.001
Asian	-1.08	0.22	0.34	-1.51	-0.65	<.0001
Latinx	-0.60	0.13	0.55	-0.85	-0.36	<.0001
Gender	0.06	0.10	1.06	-0.13	0.25	0.55
Age	0.01	0.00	1.01	0.01	0.02	<.0001

Note. Gender was coded such that 0 = male, 1 = female.

Table 2 presents the results of the ZIP regressions for race predicting experiences of racial discrimination measured in the past twelve months. Among those who reported any racial discrimination, all racially marginalized sexual minorities, were significantly associated with increased experiences of racial discrimination. The odds of being among those who reported zero racial discrimination in the past twelve months, were significant and negatively associated with all racial minorities, such that being a sexual minority of color increased the likelihood of experiencing racial discrimination.

Among those who reported any sexuality-based discrimination in the past twelve months, Black (RR = 1.32, 95% CI = 1.19, 1.46, $p < .0001$), and Latinx (RR = 1.15, 95% CI = 1.03, 1.28, $p = .01$) individuals were significantly associated with increased sexuality-based discrimination compared to their White counterparts. Indigenous sexual minorities reported less sexuality-based discrimination (RR = 0.52, 95% CI = 0.32, 0.88, $p = .01$) compared to White sexual minorities. There was not a significant difference between Asian and White sexual minorities. There were no significant racial differences among those who reported zero sexuality discrimination in the past twelve months.

Mental Health Outcomes

In regard to mental health, overall the odds of reporting zero depression symptoms were higher for all Black, Asian, and Latinx sexual minorities. These results indicate that overall, Black, Asian, and Latinx participants were more likely to report zero symptoms of depression. When Latinx sexual minorities did report depressive symptoms (i.e., when they are a non-zero, as is examined in the count model), they reported slightly more symptoms (RR = 1.06, 95% CI = 1.01, 1.11, $p = .02$). Among those who reported any depressive symptoms, Asian sexual

minorities reported fewer symptoms compared to White sexual minorities (RR = 0.77, 95% CI = 0.69, 0.86, $p < .0001$).

The odds of reporting zero anxiety symptoms were significantly and positively associated with Black and Asian sexual minorities, such that they were significantly more likely to be among those who reported zero anxiety symptoms. When they did report any anxiety symptoms, Black (RR = 0.88, 95% CI = 0.84, 0.95, $p < .0001$) and Asian (RR = 0.83, 95% CI = 0.72, 0.95, $p = .004$) sexual minorities reported fewer symptoms than their White counterparts. Overall, sexual minorities of color had greater odds of reporting zero anxiety and depression symptoms, and when they did endorse any depression or anxiety symptoms, they were more likely to report fewer symptoms than their White counterparts.

Interaction of Discrimination and Mental Health Outcomes

When depression symptoms were present (non-zero), the effect of racial discrimination was associated with more symptoms of depression in general (RR = 1.04, 95% CI = 1.03, 1.05, $p < .0001$). The odds of reporting zero depression symptoms decreased with the experience of any racial discrimination (OR = 0.78, 95% CI = 0.71, 0.86, $p < .0001$). Among those who reported depression symptoms, the interaction of a marginalized racial identity and racial discrimination produced no significant effects. The odds of reporting zero symptoms of depression increased for Black (OR = 1.20, 95% CI = 1.07, 1.35, $p = .001$), and Latinx (OR = 1.12, 95% CI = 1.00, 1.26, $p = .047$) sexual minorities experiencing racial discrimination. Experiences of racial discrimination for Black and Latinx sexual minorities was associated with an increased likelihood of reporting zero depression symptoms.

When anxiety symptoms were present (non-zero), the effect of racial discrimination was associated with more symptoms of anxiety in general (RR = 1.02 95% CI = 1.01, 1.03, $p = .003$).

The odds of reporting zero anxiety symptoms decreased with the experience of any racial discrimination (OR = 0.85, 95% CI = 0.79, 0.92, $p < .0001$). Among those who reported any anxiety symptoms, the interaction of a marginalized racial identity and racial discrimination produced no significant effects. The odds of reporting zero symptoms of anxiety were not significantly affected by the interaction of a marginalized racial identity and racial discrimination. No racial differences were found despite the association of racial discrimination with increased anxiety symptoms in general.

When depression symptoms were present (non-zero), the effect of sexuality-based discrimination was associated with more symptoms (RR = 1.02, 95% CI = 1.01, 1.03, $p < .0001$). The odds of reporting zero depression symptoms decreased with the experience of any sexuality-based discrimination (OR = 0.93, 95% CI = 0.87, 0.98, $p = .01$). There were no significant racial differences found despite the significant positive relationship between sexuality-based discrimination and depression symptoms overall. Among those who reported any depression symptoms, the interaction of a marginalized racial identity and sexuality-based discrimination produced no significant effects. The odds of reporting zero symptoms of depression increased for Black sexual minorities experiencing sexuality-based discrimination compared to White sexual minorities (OR = 1.09, 95% CI = 1.01, 1.17, $p = .001$). Similar to the effect of racial discrimination, sexuality-based discrimination for Black sexual minorities was associated with an increased likelihood of reporting zero depression symptoms. When anxiety symptoms were present (non-zero), the effect of sexuality-based discrimination was associated with increased symptoms of anxiety in general (RR = 1.01 95% CI = 1.00, 1.02, $p = .003$). The odds of reporting zero anxiety symptoms decreased with the experience of any racial discrimination (OR = 0.96, 95% CI = 0.91, 0.99, $p > .0001$). Among those who reported anxiety symptoms, the

interaction of a marginalized racial identity and sexuality-based discrimination produced no significant effects. Additionally, the odds of reporting zero symptoms of anxiety were not significantly affected by the interaction of a marginalized racial identity and sexuality-based discrimination. Similar to the outcomes for racial discrimination, sexuality discrimination was associated with increased anxiety symptoms in general, but no racial differences were found.

Racial- and sexuality-based discrimination measures were combined to examine the additive effects of compounded discrimination on mental health outcomes. Among the sexual minorities that reported any symptoms of depression, the effect from both race- and sexuality-based discrimination was significantly associated with increased depression symptoms (RR = 1.02 95% CI = 1.02, 1.03, $p < .001$) and their interaction decreased the odds of reporting zero depression symptoms (OR = 0.91, 95% CI = 0.87, 0.95, $p < .0001$). Relative to White sexual minorities, the combined effect of both racial and sexuality-based discrimination was associated with higher odds of reporting zero depression symptoms for Black sexual minorities (OR = 1.09, 95% CI = 1.03, 1.15, $p < .01$). When anxiety symptoms were present (non-zero), the combined effects of both types of discrimination were associated with an increase in symptoms (RR = 1.01 95% CI = 1.01, 1.02, $p < .001$). Additionally, experiencing both types of discrimination was associated with slightly lower odds of reporting zero anxiety symptoms in general (OR = 0.92, 95% CI = 0.89, 0.96, $p = .002$). No significant racial differences were found for anxiety symptoms from the interaction of racial and sexuality-based discrimination. Overall, the combined effects of racial and sexuality discrimination were associated with an increase in depression and anxiety symptoms. Black sexual minorities were more likely to report zero symptoms of depression relative to Whites.

Protective Factors

The potential protective influences of social support and racial identity on sexual minorities were also examined. Sexual minorities that identified as Black or Asian reported less social support compared to their White counterparts. Black, Asian, and Latinx sexual minorities reported greater positive racial identity when compared to White sexual minorities (Table 3).

Table 3:
Protective Factors

	Social Support				
	β	SE	LCL	UCL	p-value
Intercept	31.01	0.47	30.09	31.93	<.0001
Black	-1.06	0.35	-1.74	-0.37	0.003
Indigenous	-1.17	1.22	-3.56	1.21	0.335
Asian	-2.08	0.68	-3.42	-0.75	0.002
Latinx	-0.44	0.38	-1.20	0.31	0.249
Gender	0.03	0.29	-0.53	0.59	0.925
Age	-0.05	0.01	-0.06	-0.03	<.0001
	Racial Identity				
	β	SE	LCL	UCL	p-value
Intercept	22.72	0.56	21.63	23.81	<.0001
Black	6.15	0.42	5.33	6.97	<.0001
Indigenous	1.81	1.45	-1.04	4.65	0.214
Asian	4.85	0.80	3.28	6.43	<.0001
Latinx	4.68	0.46	3.79	5.58	<.0001
Gender	-0.19	0.34	-0.86	0.48	0.582
Age	0.06	0.01	0.04	0.08	<.0001

Note. Gender was coded such that 0 = male, 1 = female.

Social support was associated with fewer depression symptoms among sexual minorities that reported any symptoms (RR = .99, 95% CI = 0.99, 0.99, p = .01) and increased the likelihood of reporting zero symptoms (OR = 1.041, 95% CI = 1.02, 1.06, p > .0001). Among Black sexual minorities that reported any depression symptoms, social support was significantly associated with fewer symptoms compared to White sexual minorities (RR = .99, 95% CI = 0.98,

0.99, $p = 0.047$). Social support was not significantly related to symptoms of anxiety in general. However, for Black sexual minorities that did endorse any anxiety symptoms, social support was significantly associated with fewer symptoms compared to their White counterparts (RR = .98, 95% CI = 0.97, 0.99, $p < .0001$). Social support was negatively associated with symptoms of both depression and anxiety for Black sexual minorities, indicating that social support may play a part in improving mental health outcomes.

Positive racial identity was associated with fewer symptoms of anxiety in general (RR= .99, 95% CI = 0.99, 0.99, $p = .01$). The odds of reporting zero depression symptoms increased with higher scores of a positive racial identity (OR = 1.04, 95% CI = 1.02, 1.05, $p < .0001$). There were no significant differences associated with the effect of racial identity on depression symptoms for different racial groups. Relative to White sexual minorities, racial identity was associated with slightly increased anxiety symptoms in Latinx individuals that reported any symptoms of anxiety (RR = 1.01, 95% CI = 1.01, 1.02, $p < .001$). A positive racial identity correlated with fewer symptoms of both anxiety and depression in general. While there were no significant racial differences for racial identity on depression outcomes, Latinx sexual minorities reported higher rates of anxiety symptoms.

Discussion

The present study explored the relationship between discrimination, mental health and the potential moderating effects of social support and racial identity within a large, nationally representative sample of sexual minority adults. The purpose was to contribute to a current gap in the literature by examining the unique experiences of multiply marginalized communities and to look at the influence of race and discrimination within a sexual minority population. The impact of discrimination on the mental health of sexual minorities of color remains contradictory. The current study results indicate that in general, despite experiencing more discrimination, sexual minorities of color evidenced fewer symptoms of depression and anxiety compared to White sexual minorities, ultimately in support of the strengths and cumulative resilience that may be developed in sexual minority communities of color.

Congruent with the current literature, all sexual minorities of color reported an increased frequency of racial discrimination. The prevalence for racial discrimination is well evidenced (Bostwick et al., 2014; Buchanan et al., 2018; Buchanan & Fitzgerald, 2008; Budhwani et al., 2015; Velez et al., 2019) and these results support the hypothesis that sexual minorities of color would report higher rates of racial discrimination compared to White sexual minorities. Findings across racial groups in regard to sexuality-based discrimination provide a more nuanced racial experience of sexual minorities. Consistent with multiple jeopardy (Beal, 1970; King, 1988), Black and Latinx sexual minorities endorsed increased experiences of both racial- and sexuality-based discrimination. In contrast, the reports from Indigenous sexual minorities indicated less sexuality-based discrimination compared to Whites. The lack of significant results for the other racial groups may be due to the low levels of sexuality-based discrimination in the sample overall. The varied results for Black and Indigenous sexual minorities, when compared to White

sexual minorities, underscore the importance of recognizing the unique differences among racial minorities.

The hypothesis that sexual minorities of color would report higher rates of anxiety and depression compared to their White counterparts was partially supported. When compared to Whites, Black and Asian sexual minorities reported fewer symptoms of both anxiety and depression, while Latinx individuals endorsed increased depression symptoms. These results, when considered alongside data that suggests sexual minorities suffer from worse mental health outcomes compared to heterosexuals (Kates et al., 2018; Rice et al., 2019), with no reference to racial identities, stress the importance of looking at racial identity within a sexual minority population. Racial differences exist within a sexual minority population. A possible explanation for these differences could be the unique racial and cultural understanding of the symptoms – symptom attribution - as presented to them during the interview (Neighbors et al., 2003). Alternatively, we know that racial minorities report greater stigma associated with mental illness which may lead to underreporting symptoms (Wong et al., 2017). Finally, it may be important to note that this study sample largely reported having no symptoms of anxiety or depression. When anxiety or depression was reported, the average number of symptoms were relatively low.

Results from this study indicate a complex story of risk and resilience. The current literature indicates that discrimination is associated with worse mental health outcomes (Bostwick et al., 2014; Krieger et al., 2005; Wong et al., 2017). However, the relatively lower levels of discrimination seen in this study did not unilaterally demonstrate an increase in worse mental health outcomes. In fact, in some cases, such as the Black sexual minority group, the opposite was seen. This contradiction may be attributed to the low levels (frequency and severity) of discrimination reported. The present results showed sexual minorities of color

experienced more discrimination and yet reported fewer symptoms of anxiety and depression when compared to White sexual minorities. Additionally, the additive effects of experiencing both racial- and sexuality-based discrimination did not produce any significant positive effects on depression or anxiety. These findings are incongruent with studies that associated worse mental health outcomes for sexual minorities of color that reported increased experiences of discrimination (Bostwick et al., 2014; Calabrese et al., 2015). The present results contribute to theories that support a positive development of cumulative resilience in the face of increased adversity for individuals that are marginalized across multiple identities (Bowleg et al., 2003; Meyer, 2010). Additionally, it is possible that levels of discrimination were lower in this sample than in studies with results that support worse mental health outcomes.

These findings support a theory of increased resilience, in which sexual minorities of color are racially socialized from birth, which buffers against negative effects of sexuality-based discrimination later in life. In contrast, White sexual minorities may be experiencing identity-based discrimination for the first time and not have the skills to buffer the psychological harm of adversity (Cyrus, 2017; Meyer, 2010). Racial minorities often grow up with parents and a community that provide racial socialization. Socialization throughout child development helps racial minorities prepare for, witness examples of, and learn about the historical context of racism they will inevitably face in the United States (Brown, 2008; Fitzgerald et al., 2019; Stone et al., 2020). In contrast, the socialization of White racial identity includes internalizing beliefs of racial superiority and expectations that the rules and systems in the United States will mostly be beneficial in their lives (Allen, 2020; Hagerman, 2014). Compared to racial minorities, White sexual minorities may be less prepared to face sexuality-based discrimination. Taken together,

the cumulative resilience in sexual minorities communities of color may offer protection against multiple jeopardy at low levels of discrimination.

We would not expect to see these same mental health results if participants experienced more severe discriminatory events, such as bias motivated violence. It is well documented that higher levels of identity-based discrimination, violence, and hate crimes are associated with increased risk of suicide and poor mental health outcomes (Burks et al., 2018; Cramer et al., 2018; Frost et al., 2015; Herek et al., 1999). It is likely that these results were not replicated here due to the zero-inflated data. Overall, this sample reported fewer experiences and less severe discrimination.

In service of amplifying the strengths within sexual minority communities, findings indicated that Black sexual minorities that endorsed social support reported fewer symptoms of depression and anxiety compared to their White counterparts. This is in line with evidence that suggests social support can buffer the negative mental health consequences of racial discrimination for Black individuals in particular (Brown, 2008; Plant & Sachs-Ericsson, 2004; Sehmi et al., 2019). Additionally, results support evidence that community connectedness can improve psychological outcomes for sexual minorities (Puckett et al., 2015). These findings add to the current literature that address social support for racial or sexual minorities separately and indicates that Black sexual minorities that endorse any symptoms of anxiety or depression may also benefit.

The current results did not support the hypothesis that a positive racial identity would attenuate the relationship between discrimination and symptoms of anxiety and depression such that sexual minorities of color with more positive racial identities would have fewer symptoms. In contrast, for Latinx sexual minorities that reported any symptoms of anxiety, racial identity

was actually associated with an increase in anxiety compared to White sexual minorities. These findings are inconsistent with previous studies which found racial identity to buffer the effects of racial discrimination in racial minorities (Schmitt et al., 2014; Sellers & Shelton, 2003). However, the literature is ambiguous on how the intersection of racial and sexual identity may impact mental health outcomes in the face of discrimination. No significant effects for racial identity were identified for other racial groups.

Racial identity is a dynamic process involving family racial socialization, external environmental factors, and may change over time (Douglass & Umaña-Taylor, 2015, 2016; Townsend & Lanphier, 2007). In this study, higher levels of racial identity within Latinx individuals was associated with higher levels of anxiety. A possible explanation for these findings may be that the families of these Latinx individuals, family being a major component in one's racial identity, offer conflicting sources of support and rejection (Przeworski & Piedra, 2020). Both internalized homophobia (Puckett et al., 2015, 2018), and internalized racism (Velez et al., 2019) have been related to poorer mental health outcomes. If racial identity does not include affirming beliefs related to sexuality, then racial identity – which is often associated with positive mental health outcomes – may be associated with negative psychological effects. Further, how racial identity is measured in the literature varies widely and types of racial identity may affect this relationship (Banks & Kohn-Wood, 2007). Further exploration of the function of racial identity on mental health outcomes for racial and sexual minorities is needed.

The present study included a large national sample of adults who identified as lesbian, gay, or bisexual, or indicated any sexual minority behavior or attraction. Some studies indicate that different aspects of sexuality, identity, attraction, or behavior, differentially affect mental health outcomes (Diamond, 2014; Galupo et al., 2015; van Anders, 2015). Thus, only including

individuals that self-identify with a sexual orientation label may exclude an important part of the population, i.e. those with sexual minority behavior or attraction. Sexual behavior, not sexual identity, was associated with suicide attempts among a study of Norwegian adults (Wichstrøm & Hegna, 2003), indicating that sexual behavior may affect mental health above and beyond self-identified labels. Odds of a person reporting any mood or anxiety disorder were found to be significantly different across facets of sexual identity and sexual behavior (Bostwick et al., 2010). The present study captured the intersections of race and sexuality more broadly by including individuals across the spectrum of identity, behavior, and attraction. Taken together, it is clear that sexual minorities of color experience nuanced, and divergent, experiences of discrimination which differentially impact mental health outcomes.

Limitations and Future Directions

The present study used a robust, nationally representative sample with a multidimensional measure of sexuality. Having a large sample allowed for analyses within a racially diverse sexual minority population rather than comparisons between sexual minorities and heterosexuals. The study was able to demonstrate support for a strengths-based model of cumulative resilience within sexual minority communities of color. Even so, there are some potential limitations to address.

While minimal mental health concerns and low frequency of discrimination is certainly a welcome result, they should be carefully considered. NESARC-III data was collected in person and in the home of the participants. Compared to anonymous internet surveys, face to face interviews may result in less truthful responses or be affected by stigma and fears of disclosing information related to sexuality (Bjarnadottir et al., 2017; van Eeden-Moorefield et al., 2008). Racial matching between the interviewer and interviewee has been shown to promote greater

disclosure in regard to discrimination due to perceptions of more shared experiences and mutual understanding of racial discrimination between the interviewer and participant (Egharevba, 2001; Vakil et al., 2016).The demographics of the interviewers in the current study are unknown, however it is a possibility that the face to face data collection negatively impacted participant's responses (Hayfield & Huxley, 2015).

Another limitation of the current study is the way in which discrimination was measured. The EOD Scale (Krieger, 1990), combines different types of discrimination across different situations into a singular question. For example, they asked how often one experienced discrimination when obtaining a job or on the job, getting admitted to a school or training program, in the courts or by the police in the same question. Another item asks how often they have been made fun of, picked on, pushed, hit, or threatened with harm. Responding with a frequency to one of these questions could indicate that someone is threatened with harm very often or that they are picked on very often, or both. These experiences, while both negative, are not of the same severity and could provide greater insight if measured separately. To examine the effects of discrimination it would be helpful to be able to measure the differential effect of being made fun of very often compared to being threatened almost never. Further, these items focus mostly on interpersonal interactions involving discrimination and may not adequately capture institutional and systemic forms of racism and oppression.

Lastly, the mental health outcomes of this study were confined to symptoms of depression and anxiety. It is possible that the effects of discrimination may impact other mental health measures outside of mood or anxiety disorders. Further, it is possible that the measures of anxiety and depression within this particular sample did not adequately measure their current levels of distress. Given that the current research is ambiguous on how racial and sexuality

discrimination affects sexual minorities of color, it may not directly result in anxiety or depression at all. It is reasonable to consider other potential coping mechanisms such as substance use, binge eating, or measures of post-traumatic stress disorder to better capture the effects of discrimination.

Despite the limitations of this study, the findings contribute a strengths-based perspective on the effects of low levels of discrimination on symptoms of depression and anxiety in sexual minorities of color. Compared to White sexual minorities, sexual minorities of color reported fewer symptoms of anxiety or depression despite experiencing more frequent racial- and sexuality-based discrimination. These findings highlight increased resilience in sexual minority communities of color. Social support was a significant protective factor for Black sexual minorities that reported any symptoms of depression or anxiety. By using an inclusive measure of sexuality, the implications of these findings are more generalizable. Future research and methods of measuring strength and risk factors across intersecting identities are needed to understand the experiences and potential sources of resilience in multiply marginalized populations.

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